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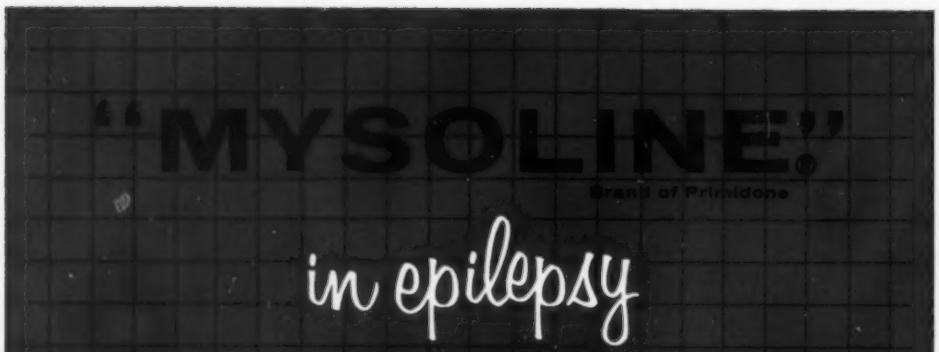
American Psychiatric Association



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Mental Hospitals

Volume 8
Number 8

CONTENTS, OCTOBER, 1957

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THIS MONTH'S COVER

An experimental form of entertainment for patients —a fashion show—was tried out at the Dix Pavilion, St. Elizabeths Hospital, Washington, D. C. It was the idea of one of the nurse-supervisors, Mrs. Notrevee Arrington. A Red Cross volunteer, Mrs. Trudy Davis (at right in photograph, standing behind the table), who is a fashion designer, was asked to come and spend an afternoon demonstrating make-up and hair styling along with current fashions. She showed three patients how to improve their looks with properly applied cosmetics and a hairstyle suited to their personality. After each demonstration, another volunteer modeled different types of clothes, from casual daytime dresses to evening gowns.

The audience, about 50 patients and visitors, responded enthusiastically to the amazing transformation of the three girls. Everyone was most cooperative and seemed to enjoy the show, which was followed by a short period of questions and answers. One girl wanted to know how she could arrange her hair to make herself more attractive, since she was so short and chubby. Another one, what she could do about her eyebrows. One of the patients who was a model in the cosmetic demonstration went to the supervisor after the show to ask whether she could now wear her own clothes. Up to that point, she had seemed perfectly satisfied with her hospital dress.

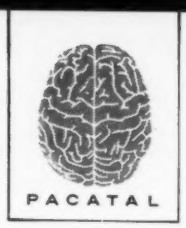
Refreshments were served by patients and there was an atmosphere of lively social gathering throughout the gaily decorated dayroom.

Was the experiment worthwhile? The answer was given by a patient: "It was wonderful. It was like a breath of the outside world!"

In the months since the show was held, nursing personnel on Dix Pavillon have observed that some of the women patients do seem to take more interest in their appearance. Good grooming is encouraged by ward attendants who, on their own initiative, occasionally get groups of women patients together on the ward to try out different hair styles and make-up and give each other home permanents. Professional beauty care, from manicures to permanent waves, is available in the Pavilion's well-equipped beauty shop.

Good clothing care is also encouraged, particularly of the patients' own clothing. A laundry room in the basement of the building is equipped with two automatic washers and dryers and two ironing boards. Here the patients, men as well as women, can launder any of their clothing they do not wish to send to the hospital laundry.

The fashion show-cosmetic demonstration was so successful that the staff hopes it can be repeated, perhaps yearly. Along this line, Miss Helen Carter, evening supervisor of nursing on Dix Pavilion, suggests that if one or several of the local department stores were to sponsor showings of their inexpensive fashions at the hospital, quite a few of the patients would ask their relatives to bring them new clothing and would thus take greater interest in their personal appearance.



"Mommy, play with me, Mommy!"

She can, now. But only a short time ago Doris never had time for the kids.

A "crazy-clean"housekeeper, she chased dirt and germs all day long. This endless ritual seemed pointless, even to her, yet she couldn't help herself. She became short-tempered with the children . . . cried for no reason at all . . . was depressed and indecisive. Because her compulsiveness crowded out normal living, and Doris was on the brink of a serious breakdown, Pacatal was instituted: 25 mg. t.i.d.

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MANAGEMENT AND THE PUBLIC MENTAL HOSPITAL

By ADDISON M. DUVAL, M.D., Assistant Superintendent
St. Elizabeths Hospital, Washington, D. C.

Few mental hospital superintendents have a clear conception concerning scientific management as it is known in American business today. When the question of improvement in hospital management is raised, some hospital administrators think only of bringing in an auditor, a finance officer, a personnel director or a fiscal expert. They rarely think about improving their own management knowledge and skills, or those of the medical staff. They tend to think of themselves as physicians rather than managers, and somehow it seems natural to them to place the responsibility for all management on the personnel officer or the top "business man" in the hospital.

Such an attitude can jeopardize the whole future of American psychiatry by allowing the operation and administration of public mental hospitals—which care for 97% of mentally ill hospital patients—to pass out of medical control into the hands of laymen. If psychiatry abdicates its responsibility for these patients, it will rightly lose the support and respect, not only of the medical profession, but also of the general public.

In a recent report,* I attempted to show why the superintendent of a mental hospital must be a psychiatrist. In the present report I want to point out the need for this psychiatrist to have management training, since only through such training can he be prepared to accept his *full* responsibility as the top operating official of the hospital. Such training will not only improve the clinical operations of the hospital, but will do much to eliminate the criticism which has been levelled, and with some justification, at some superintendents because of their ignorance of management principles and operation.

Certain healthy trends are developing at present which give promise of improved management training for the future The American Psychiatric Association, through its Committee on Certification of Mental Hospital Administrators, is attempting to set up standards for management training and is encouraging the establishment of proper courses of study and training leading to proper certification.** Among these courses are those established at Columbia University and at The Menninger Foundation School of Psychiatric Administration. The development of more short seminar-type courses would be useful to superintendents and other hospital psychiatrists, whose need for this training is great, but whose time is too limited for them to take a one or two year course.

What most of us in the psychiatric field do not realize is that there are well-established principles, skills and tools of management which are just as applicable to public mental hospitals as to companies making automobiles. This I learned recently during an intensive four-week management course given by the American Management Association. I am the only psychiatrist so far who has taken the course and its impact on me was truly significant. I learned many new facts, as well as how to meaningfully integrate isolated pieces of knowledge into a practical and clear understanding of management in everyday use.

As these broad basic principles of management remain essentially constant, no matter what the organization, one needs only to make the special type of application to fit an individual management problem. These principles apply not only to the top administrative psychiatrist, but to the assistant superintendent, clinical director, the chief of a ward service, the chief nurse, the social service director and all other supervisors in the mental hospital. Each of these individuals, responsible for one or more phases of the total operation, cannot help but be a manager too.

In attempting to present a thumbnail sketch of the principles, skills and tools of management, I will rely

Continuing this series, as from next month, a business manager, a superintendent, a chief nurse and other department heads will show how the principles outlined in this paper apply to their own operation. The purpose of the series is to focus attention on improvement of mental hospital management.

* *Must the Mental Hospital Superintendent Be a Physician-Psychiatrist? Yes, by Addison M. Duval; No, by Robert H. Klein & Paul E. Feldman. Hospitals, 31:34-36, 37-38, 98, 100. Jan. 16, 1957.*

** *Administrative Psychiatry: A New field—Challenging and Rewarding. W. Terhune. J.A.P.A., Vol. 114, No. 1, July 1957.*

The Medical Superintendent's Dilemma

The physician-superintendent of the large mental hospital faces a great dilemma: should he hope primarily to be a first-rate psychiatrist or to be a professional hospital manager?

Through the past century or more, the medical superintendent has been noted for his contributions to psychiatry. The institution, for better or worse, has been a reflection of his professional psychiatric viewpoint on the care and treatment of his patients. He has indeed maintained leadership in the field of psychiatry.

It would be disastrous if he lost this leadership yet it is becoming increasingly difficult to maintain as the lore and scientific background of psychiatry become more complex. At the same time the duties of hospital management have likewise become more complex, and are developing into a new science—that of hospital administration.

This dilemma confronts the psychiatric profession and the administrative heads of state departments, and there is no ready solution in sight. There is a pressing need for the best minds to turn their attention to the problem of finding a satisfactory solution or solutions to the dilemma.

HARRY C. SOLOMON, M. D., Superintendent
Massachusetts Mental Health Center, Boston

heavily on the concepts presented by the American Management Association in the Management Course which I have just completed.

I. DEFINITION, BASIC PRINCIPLES AND ELEMENTS OF MANAGEMENT

Management is a profession, an art and a science. Certain facts and principles are known, specific aptitudes and skills are required and the scientific method is applicable. Several definitions may be used for clarity. (1) Management is getting things done through people. (2) "Management is guiding human and physical resources into dynamic organization units which attain their objectives to the satisfaction of those served and with a high degree of morale and sense of attainment on the part of those rendering the service".*

From these illustrative definitions it is readily seen that management is not limited to industry or finance, but is applicable to government, to farming, to church, to medical services or to any activity where groups of workers are involved.

Basic Principles

Certain basic principles can be applied to all management. The following are examples:

1. Management is the development of people; it *is not* the direction of things.
2. Objectives—long-range and short-range—must be established.
3. Activities to be performed must be carefully and clearly determined.
4. Organization must be dynamic.
5. Responsibility and authority must be delegated within specific limits.
6. There must be a balance between physical and human resources.
7. There should be high morale and true job satisfaction of employees.
8. The honesty and integrity of the manager is a necessity.
9. Those served must be satisfied.
10. Definite controls must be established through review and appraisal.

Elements of Management

Analysis shows that management can be divided into elements which can be considered individually.

Two of the basic elements of management are Planning and Controlling.

Planning

Every management operation should be well planned or else it will be less effective. All planning includes policy formulation. A policy is really a plan of action which is best set down in writing. Planning must include (a) the setting of objectives; (b) the establishment of procedures required to reach the objectives; and (c) the assignment of responsibilities to individuals or organizational units.

Detailed discussion of these three requirements cannot be given here but the reader can readily apply this planning procedure to his own operation. Objectives are usually both short range and long range. With mental hospital operation such things as replacement of physical facilities, current and future patient loads, changing types of treatment programs and the like would all be pertinent to the establishment of objectives. The development of written procedures as to how we reach our objectives is time consuming but quite necessary.

The assignment of responsibilities is often a more difficult problem and fraught with many pitfalls. Many times we assign the responsibility without giving the corresponding authority. It is useless to expect a good job to be done by a staff member when he is required to operate without assigned objectives, without written procedures and without proper delegation of either authority or responsibility.

Quite probably the long established hierarchy in some mental hospitals, where the superintendent sits on a pinnacle as the father figure exercising parental control over his children, has much influence on inhibiting proper delegation of authority and responsibility. In such situations the staff member has to "play by ear" and soon he comes to know that his best method of avoiding the criticism of his boss is to do everything he does most conservatively, to take no therapeutic risks with his patients

* *From Lectures, Management Course, Appley. American Management Assoc., New York, 1957.*

and to do nothing that will gain him any special attention. This is a deadening experience to the staff member and is an excellent way to kill interest and initiative. Whether this detrimental aspect of the climate of such public mental hospitals will disappear with our generation remains for the future to reveal. We hope so! A painfully honest self-appraisal by each of us seems indicated.

After we have established objectives and procedures for reaching these objectives and have assigned duties and responsibilities to individuals or units, we then turn our attention to the second basic element of management—controlling or reviewing. As a primary requirement, we must have good balance between planning and controlling.

Controlling

Controlling is getting the planned job done. It includes review and appraisal. Controlling requires good supervision but not necessarily centralization of authority. It most certainly requires proper delegation of authority and responsibility. It includes establishment of sound organization structure which makes it possible for groups to work together as effectively as individuals would work alone. Controlling is made up of two elements (a) organizational structure and (b) supervision.

(a) *Organizational Structure*

Some managers consider a beautiful organization chart as an end in itself. Nothing of the sort is true. The organizational structure should be simple and factual and should fit the specific management function to be served. Care must be taken to guard against too great a number of units reporting to one person on the one hand or too deep vertical organization on the other. Breadth and depth should complement each other with the aim being a clear and practical set of relationships between supervisors and those supervised. Otherwise there will be frictions, misunderstandings, jealousies and petty personal politics which impede good function and impair morale. Good organization is essential to good management.

(b) *Supervision*

The second element of control is supervision and most particularly immediate supervision. In recent years the role of the unit supervisor has increased in importance. We now believe that good immediate supervision is a requirement for successful operation, but we still give too little attention to the supervisors' training for supervisory duties. Often we promote an employee to a supervisory position because of long and satisfactory employment but with no thought as to whether he has the qualities, training and abilities of a supervisor of others. Proper function is difficult if not impossible without good immediate supervision.

The Executive Function

In order that the elements of management may be carried out with the greatest efficiency we apply what may be called the executive function. This is the action program of the manager as applied to his particular job. Management is now investigating this area quite intensively and the scientific studies of the processes of decision-making should produce new and helpful information. The executive function includes:

1. Determining what people are to do.
2. Selecting the most qualified people to do it.
3. Checking periodically how well they are doing it.
4. Finding methods by which they will do it better.

It is rather easy to list these requirements but it is more difficult to effect them. Constant and diligent attention will usually produce results.

The Management Formula

The American Management Association has suggested a formula which if applied to a management problem step by step gives assistance in its solution. Let us inspect this formula in some detail.

The seven steps in the Management Formula are as follows:

1. Organization Clarification.
2. Standards of Performance.
3. Review and Appraisal.
4. Action to be Taken.
5. Source of Action.
6. Time Schedule for Action.
7. Incentives and Rewards.

The methods by which this formula is applied will vary with conditions and with managers but the basic approach remains the same. Space does not permit the discussion of each element in this formula. Organization Clarification is self-explanatory and self-descriptive. It must include good communication, both vertical and lateral. Standards of Performance are statements of conditions that will exist when the job is well done. Such standards should be written for each job following the writing of the job description. This is sometimes difficult but once established, such standards give us a good yardstick for personnel rating purposes. Along with rating comes Review and Appraisal of both the work and the workers. Strong points and weak points in the operation are established. Decisions covering the action to be taken to correct deficiencies, the source of this action and the time schedules for improvement all are finally completed and our new course set. The place of incentives and rewards in our plan of action is important to the outcome and must be clearly delineated.

II. MANAGEMENT SKILLS

Management skills comprise our second major topic of discussion. Skill may be defined as: (1) Ability; (2) Familiar knowledge as shown by dexterity in execution.

Skills in management are made up of those abilities and familiar facts which are well established and of long standing, along with new ones as they are tried and found successful. Therefore, no list of skills is complete or quite up to date in a dynamic organization. We are more interested here in the general skills of management rather than specific technical skills such as those relating to therapy or budget control. The general skills of man-

agement can be identified and made the learning and using goal of the manager. Some of these are:

1. Maintaining good economic health of the organization.
2. Integrating viewpoints of people and of functions.
3. Instilling proper motivation.
4. Making the organization dynamic and adaptable.
5. Providing rewarding satisfactions and relationships of employees.
6. Establishing good community relationships.

No effort will be made here to break down these broad skills into more specific skills such as forecasting, appraising, communicating or decision making. Skills in management can be taught and learned and then applied to the operation of mental hospitals. These skills make up the what, why, when, where, who and how of the management operation. On the learning of management skills by the mental hospital administrator (who *must* be a psychiatrist!), depends the success or failure of effective hospital function. We cannot avoid this responsibility.

III. TOOLS OF MANAGEMENT

Just as there are tools which the surgeon or physician uses in his professional practice, so there are tools of management which the executive must learn to use with skill. These tools of management, as of medicine, are constantly being developed and improved and under no conditions should remain static.

It is important to point out, however, that these management tools are usually as applicable in broad scope to mental hospital administration as to administration of an industrial corporation. Broadly, these tools relate to physical and human resources and their interrelationship. For full effectiveness each manager should have full knowledge of the most modern tools relating to his special operation, together with the ability to put them in use. These tools are primarily made up of methods and techniques. The mental hospital superintendent could select from the following list* those tools which are applicable to his situation:

1. Forecasts, e.g. (1) patient load; (2) availability of staff.
2. Research in (1) physical resources and (2) human resources.
3. Plans (1) policies; (2) formal program; and (3) budgets.
4. Standards of Performance—(1) engineered and non-engineered standards and (2) quantity, quality, cost and time standards.
5. Procedures—standard practice manuals.
6. Personnel Selection Techniques—(1) resumés; (2) tests; and (3) interviews.
7. Organization Structure—(a) position specification—(1) position description; and (2) position qualifications; (b) organization charts manuals; (c) activity analysis.
8. Personnel Utilization Techniques—(a) training and education; (b) work simplification.
9. Controls—(a) cost systems; (b) financial statements (c) break-even charts; (d) return on investment analysis; (e) work measurement; (f) internal auditing; (g) statistics.
10. Appraisals—(a) management audits; (b) progress reports; (c) conference, group, multiple appraisals; (d) rating systems.
11. Rewards and Incentives—(a) job analysis and evaluation; (b) income surveys; (c) financial and non-financial incentives.
12. Communication Systems.
13. Executive Time Budgets.

Because of lack of space no detailed discussion of each of the tools listed can be given here. It is hoped that in later communication this can be done. I think the reader can use this list and apply it to his individual executive function with the result that he may find he has not previously been using all the tools which would be helpful to him. For instance, in my own situation I was not previously convinced of either the importance of Standards of Performance or of the fact that such standards could be written for any and every job. I am now convinced of both and, further, I believe the lack of such standards is a major handicap in mental hospital management today. It is the prime reason why we have such poor immediate supervision in most hospital services. This is but a simple illustration of how the hospital administrator can extend his knowledge and insight into the principles, skills and tools of management if he but have the motivation and determination for management improvement. Personal guidance as to courses, seminars and conferences in scientific management can be secured from various Schools of Business Administration, the A. P. A. Committee on Certification of Mental Hospital Administrators, and the American Management Association.

I should point out that my discussion here of management and the public mental hospital is obviously sketchy and incomplete. Effort has been directed primarily to developing a framework on which scientific management can be erected, integrated and clearly understood. Such an approach may hopefully bring order out of disorder and clarity out of confusion. However, important topics have had to be omitted altogether or only mentioned in passing but omission in no way implies lack of importance. Some of these topics are:

1. Historical development of scientific management.
2. Philosophies and creeds of management.
3. Preparation for management.
4. Qualifications of the manager.
5. Effective communications systems and feedback.
6. Incentive and awards programs.
7. Management development of staff.

My aim here has been to present a brief outline of a simple and direct approach to the understanding of Management and the Public Mental Hospital in the hope of stimulating and encouraging other psychiatrists to interest themselves in this very important topic for the reasons stated. Failure may spell the end of the notable progress in improving our public mental hospitals which has been so apparent since the close of World War II. The tragedy would be that we fail by default!

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* *From Lectures, Management Course, Appley. American Management Assoc., New York, 1957.*

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The Standard Ration Allowance

By KATHERINE E. FLACK

Director of Nutrition Services, New York Department of Mental Hygiene, Albany

ADMINISTRATORS OF HOSPITALS for the mentally ill appreciate the value of some type of control which establishes a standard of operation and indicates the estimated need of the patient. Many states have become interested in developing food ration allowances in an attempt to provide adequate food to meet the nutritional requirements of the residents within their institutions. An effective food control system based on such a ration allowance provides the administrator with evidence of the proper expenditure of funds and may even justify a request for an increased appropriation.

The success of such a program depends upon the adaptability of the food ration to the characteristic food pattern of the group; the attention centered on details of preparation and service of food produced or purchased; and the competence of the institution's food staff. There are five steps in the development of a satisfactory food control system.

1. The analysis of the population within the institution and a determination of the nutrients required for such groups.
2. A study of the characteristic food pattern as indicated by previous food issues and an analysis of the nutrients provided by this pattern.
3. The classification of foods into significant groups to be studied in relation to nutrients provided or the satisfaction the food group brings to the dietary.
4. Planning a revision of food uses to improve the nutritional value of the foods to be served.
5. Establishing the food ration allowance in terms of pounds of the different food groups to be used per person per day in order to meet the nutritional requirements of the residents of the institution.

In analyzing the population of an institution we are concerned with the per cent distribution of the sexes, the range of age of the residents, and the degree of activity of the members. There is very little literature available on the nutritional requirements of mixed groups and still less has been published on the needs of the mentally ill patient. Therefore it becomes necessary to estimate the energy expended by the different groups and the nutrients necessary to maintain good nutritional status.

The "Recommended Dietary Allowances" published by the Food and Nutrition Board of the National Research Council forms a standard for the requirements of a "normal" individual. With this as a base we are able to calculate the nutritional needs of the percentage of the population considered as general psychiatric patients. This may represent approximately 70% of the total population, and of this group half may be ambulatory and the remainder sedentary. Today, approximately another 17% of the patient population may be workers, half of whom may be doing hard work; the remainder may be considered physically active. Referring to the tables for the "normal" individual it is possible to weight the average nutrients required for these groups and develop a table of requirements for this population in terms of a "normal" person. Special diets and extra nourishment may be required for approximately 13% of the total population and even though the special diets may be a modification of the basic diet, it is wise to allow a more liberal allowance of the food groups.

Waste Allowance Should Be Added

When the total weighted requirements are finally calculated, an additional 15% should be added to cover unavoidable waste in preparation and handling until efficient procedures are developed to control these factors. Finally, this table of requirements, representing the needs of the resident population, becomes a measuring device to evaluate the adequacy of present food consumption.

The characteristic food pattern of the group is usually influenced by the cultural background of the groups but may also be affected by budgetary limitations. If food is diverted to employee and staff from the main supply, this quantity must first be estimated and subtracted from the general use. An analysis of the consumption or food issue records of the hospital for a representative period then indicates the usual food pattern. The nutritive value of this pattern should be calculated to determine the adequacy of the diet.

It becomes necessary to classify foods into significant groups in order to simplify the development of a food ration allowance. The cost of the food selected within a group determines the cost of the total dietary. The animal proteins are important as a separate group since they not only provide protein but also contribute to the satisfaction of the meal. Eggs, cheese and milk may be treated as a separate protein group since they also provide valuable calcium to the dietary. These two groups are the expensive foods in a ration. We are especially concerned with food providing calcium when the population has a predominance of either children or geriatric patients. When economy is a factor, powdered eggs may be used

to supplement shell eggs in baking and nonfat dry milk may supplement the fluid milk supply.

Nutrition research studies indicate that all the essential amino acids (protein components) must be present at the same feeding in order to have them used efficiently by the body. They also show that the total protein of the diet is more effectively utilized if it is equally distributed throughout the meals of the day. On a low cost ration allowance the amino acid of the cereal and vegetable proteins should be supplemented by the addition of such products as soy flour or grits, processed wheat germ, inactive dry yeast or nonfat dry milk to produce a vegetable protein combination approaching that of animal protein. Eventually the cereal group can be reduced when the new ration allowance provides greater variety of food for the dietary, and the patients learn to accept this variety.

The fruits and vegetables are essential in an acceptable diet and are better controlled if divided into citrus fruits and tomato products which contribute Vitamin C to the dietary, leafy green and yellow vegetables which are an important source of both Vitamins A and C, and other fruits and vegetables which provide eye appeal to the dietary although they are not rated as high a source of these nutrients.

Fats, oils, sugars and cereals needed to furnish calories and a pleasing diet might form another group. These can be costly items in the dietary if not controlled.

Comparison of Food Patterns Possible

When the foods have finally been classified in the groups to be controlled, it is then possible to compare the analysis of the characteristic food pattern with the determination of nutrients required for the residents within the institution. The objective of the revision of a food pattern is to improve the nutritional status of the patient and to help establish better eating habits.

Usually the equitable distribution of protein throughout the day can only be accomplished by changing the meal pattern. Frequently the institution noon meal is the largest and contains the total meat allowance. The introduction of casserole and meat extended dishes is one solution to such a problem. A more satisfying evening meal may be presented if the heavier desserts also become a part of this meal.

When a basic menu pattern is finally developed which meets the estimated nutritional requirements of the weighted average patient for a given period of time, it is possible to calculate the quantities of the various food groups required to meet this pattern. The sum total of each food group divided by the days of the period will yield the pounds per food group per person per day required and becomes known as a food ration allowance.

The standard ration allowance is used as a basis of dietary planning. This planning includes estimating of total food needs which may be purchased, locally produced or contributed by government surplus, cost accounting and estimating budget requirements, as well as nutritional accounting. It may demonstrate the need for change in operational procedure. It offers a method of evaluating the effectiveness of the program and provides evidence of the proper expenditure of funds or justification for increased appropriations.

BASIC MENU PATTERN

BREAKFAST

4 ounces citrus fruit 5 times a week, stewed dried fruit twice
1 egg portion 4 times a week (3 eggs used weekly in cooking)
Dry cereal once a week, cooked cereal 6 times a week, fortified with soy grits and wheat germ
4 ounces milk and sugar to sweeten cereal
2 slices toast with butter or oleo
Coffee with milk and sugar

DINNER (Main Meal)

Main dish:

Beef roast once a week (42 pounds per 100)
Beef stew once a week (31.5 pounds per 100)
Meat loaf or similar product once a week (21 pounds per 100)
Fish or similar product once a week (25 pounds per 100)
Ham, veal or chicken once a month plus beef roast (42 pounds per 100)
Frankfurters every other week (20 pounds per 100)
Pork roast every other week, alternate with beef liver

Vegetables:

Potatoes used daily
Green beans, peas, cabbage, and carrots, each once a week
Spinach or Swiss chard once a week
Beets or squash once a week
Corn once a week
Alternate vegetables, 2 servings used at supper meal during week: tomatoes; eggplant; onions; rutabagas; sauerkraut
Bread, 2 slices with butter or oleo
Milk, 6 ounces per patient
Coffee or tea with milk and sugar

Desserts (light ones used with dinner meal):

Rice or tapioca pudding once a week
Flavored gelatin once a week
Cornstarch pudding once a week
Fruit pudding once a week
Fruit (fresh), bananas or apples
Stewed fruit dessert

SUPPER

Main dish:

Meat extended dishes 3 times a week (21 pounds per 100)
Ham extended dish or corned beef (25 pounds per 100)
Sliced bologna or fish extended dish (21 pounds per 100)
Fish extended dish 9 times in 26 weeks (15 pounds per 100)
Meatless meal remaining evenings: scrambled eggs or omelets; baked beans; baked macaroni and cheese; spanish rice, etc.

Salads (or hot vegetable twice a week):

Cabbage slaw once a week
Carrot and carrot combination salads once a week
Lettuce salads once a week
Celery, cucumbers, radishes, or green onions once a month but used only in season
Tomato during season; during winter months, green bean salad
Bread, 2 slices with butter or oleo, jam occasionally
Milk, 6 ounces
Tea with milk and sugar

Dessert:

Cake twice a week
Doughnuts once a week
Pie once a week
Cobbler or fruit pudding once a week
Fruit as dessert with cookies twice a week

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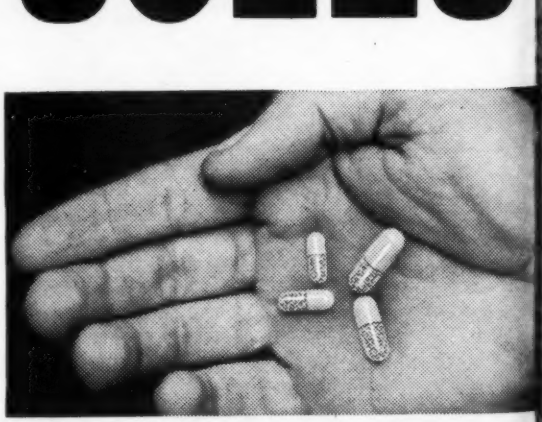

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WHAT IS A THERAPEUTIC COMMUNITY?

Report of a Three-Day Hospital Workshop

By THOMAS J. HARDGROVE, M.D., Manager
and JOHN R. SCHLOSSER, Ph.D., Chief, Clinical Psychology Service
Veterans Administration Hospital, Sepulveda, California

AT WHAT POINT does team decision-making become unhealthy relinquishment of psychiatric responsibility? Is a hierarchical hospital structure—the kind accepted by most businesses, all military organizations, and most hospitals as administratively economical and effective—incompatible with socio-psychological treatment programs? Which patients should receive priorities where staff is limited? How can we justify *communication time* when we have so little *treatment time* available? What is a "therapeutic community?" What can a "therapeutic community" do? What problems does it introduce?

These and many other equally soul-searching questions were discussed by a wide variety of mental health professional workers during a three-day workshop sponsored by Veterans Administration Hospital, Sepulveda, California. It was attended by some four hundred representatives of hospitals, universities, mental hygiene clinics, placement agencies, and other groups associated with the treatment and rehabilitation of mental patients.

Needed—A Practical Formula

One of the prominent themes in the early sessions was the plea for a formula by which a therapeutic community might be started—a request for the prescription by which one could develop such an entity. Delegates were hunting for some immediate and directly applicable rules by which they might guide themselves and other hospital workers.

As the workshop proceeded, however, it became apparent that, while one might describe the shell of a therapeutic community, the necessary attitudes and philosophies—the ingredients which make it work—are difficult or impossible to prescribe. "How does one go about teaching virtue?" asked one participant. A therapeutic community, complained others, might be possible in hospitals with a favorable staff-patient ratio but it was too much to expect or even work for in less fortunate hospitals. One of the participants observed that it was much easier at new hospitals (such as the host hospital for the workshop) to plan and actually create a therapeutic community but that it was difficult to change an existing, essentially anti-therapeutic community into one which permitted a therapeutic process to take place. Another observed that many of the people came hoping to learn a technique of treatment they could take back to their hospital and found, instead, that they were being asked to scrutinize their deep convictions, their basic attitudes, and their views on mankind in general.

There was eventual agreement that a therapeutic community *is* desirable (if for no other purpose than to evaluate its effect through research), and acceptance of the principle that attitudes and philosophies determine the effectiveness of any community purporting to be therapeutic. As a result, the discussion turned to methods or stratagems, and to the locus at which these should be applied in order to effect the necessary changes in attitudes and philosophy.

One specific attitude considered basic to any socio-psychological approach to patients (and "the therapeutic community" was considered to be such an approach) was the view that at least part of a chronic psychotic condition actually reflected adaptations of patients to an inhospitable or an indifferent setting, in contradistinction to the view that such chronic conditions are the result of an inevitable and irreversible disease process of one kind or another. The interaction of patients with their environment should be seen as providing one condition in which the adaptation process can be undone or redone under more favorable circumstances. The hospital environment should seek ways to adapt to the patient rather than asking the patient to conform to the hospital. This would call for continuing self-evaluation by the hospital culture and the modification of observed non-therapeutic or anti-therapeutic conditions. Tolerance is needed for the transient tensions resulting from the patient's freedom to respond with external changes as his internal structure changes—and tolerance also for his frustrations, disappointment and anger when mistakes are made. Collaboration between staff and staff, staff and patient, and patient and patient should take the place of direct control and policy-making at any single and "higher" level of authority. The roles of individual staff and patients should be explored and expanded on the basis of demonstrated capacities.

Finally, the necessary attitudes should be those which would guarantee both to patients and staff "the dignity of the person . . . and the preservation of human rights, including those of privacy, self-determination and attention to personal comfort." The physical and psychological environment should be characterized by lack of coercion, by an opportunity for useful interpersonal relations in work, play and social functions, and by an atmosphere of liberty, initiative, and useful activity.

"Grass-roots" or Management Leadership?

New attitudes or philosophies first develop in a hospital in the form of tiny and often widely separated "islands of belief", said a participant. These islands

grow in size as increasing numbers of the personnel come to understand and accept the new concepts until they finally take over "the mainland." A psychiatric nurse commented that there were many different levels of therapeutic communities throughout any hospital, the level determined by the type of patient being treated (and therefore upon his capacity to deal with responsibility, freedom, expectations, etc.), and the level of development of the therapeutic team in that area.

Any therapeutic community will be sure to collapse, cautioned another speaker, unless it has both the emotional and intellectual support of the administrative head of the hospital. The comment was made with reference to the establishment of patient governments, and patient councils, but applies also to other situations, where patients and non-medical staff take a more active part in problem-solving and decision-making.

"This is so because crises are bound to arise from time to time when patients in an essentially authoritarian setting—one in which both staff and patients have traditionally functioned in accord with the dictum 'the doctor knows best'—are given the invitation and the opportunity to practice more self-reliance and take more responsibility for their own welfare," this speaker said. "If top level administrators and supervisors cannot tolerate such crises and allow people a chance to work out group solutions—if they react prematurely and with restrictive decrees, the patients involved cannot help but be aware that these decrees reflect an essential lack of faith in them, as well as a gulf between the philosophies expressed by the building staff and by management. Since the position of the former is subject to reversal by the latter, the patients are bound to grow cynical and lose interest, or go through the motions of operating patient government with increasing apathy. Moreover, patient government cannot be kept in a vacuum and will have a decided impact on the entire hospital culture . . . Thus, management which permits the establishment of a patient government anywhere in the hospital will be well advised to consider the demands which will be made on it in consequence. This decision cannot be made lightly; no ward team should embark on patient government without first working out the issue of support explicitly with management."

The tenor of a hospital is determined by the attitudes of the top administrator as expressed by him or as inferred by others, commented another speaker. He advocated formal training of hospital administrators to familiarize them with the "whole new accumulating body of knowledge about how you can get scientific and technical about a social system." He stressed the need for clinical action research to substantiate theories of group dynamics and to solve the social problems.

Patient Views on Patient Participation

It would be to the benefit of the therapeutic community if patient government was viewed as one of the most important projects in the hospital, declared one of the members of a patient panel from the host hospital, which took part in the workshop. (All were or had been officers of patient governments or patient councils.) He thought we should never give up the idea of patient government even if the interest of the patients themselves slacked off at times. It should be a definite hospital plan to institute and support patient government. At the present time, the full potential of this program was not being used, because hospital administration did not put sufficient emphasis on its importance. He added that the existing rules and policies of the agency controlling the hospital often restrict unduly what the staff can do; staff must comply with regulations and must work within certain boundaries, even if they agree that a certain change might be desirable.

Responsibility vs. Delegation?

How far can the responsibility for making decisions be shared with a treatment team or with patients? One physician maintained that this sharing sometimes involves unhealthy relinquishment of psychiatric responsibility. He asked for slow and careful introduction of new methods lest we abandon the constructive and useful aspects of present forms of treatment; many of the benefits of the therapeutic community might be obtained within the framework of a hierarchical hospital structure. Yet the collaborative aspect of the team approach is extremely important, replied another physician. The feeling of sharing co-therapist status dissipates many of the common problems of interdisciplinary friction and prerogatives. There is a distinction between *relinquishing responsibility* and *relinquishing some of the traditional techniques of exercising authority;* the physician has ultimate responsibility on the hospital ward unit, but he may adopt new ways of mediating his authority in order to serve therapeutic ends. Our objective in treatment is, as far as possible, to help patients internalize control in varying degrees and for varying lengths of time. Thus external controls should vary to meet the patients' needs. Many participants commented that sharing in decision-making is the main factor in the high morale observed among staff and patient groups where group decision-making and problem-solving is the rule.

Free delegation of authority for planning and operation need not imply relinquishment of final responsibility, which is exercised by management's system of review and evaluation. It is unfair, however, to "second-guess" decisions and actions of subordinates through the use of "hindsight" or information not available to the subordinate when he made his plan, nor should the enlightened manager countermand or veto the plans of subordinates merely because they do not conform in detail to what he had expected. Delegation of responsibility must carry with it the delegation of commensurate authority, and the support and confidence of the delegating person; review, evaluation, and "feed-back" are essential to build a satisfactory organization.

A hospital is a social system, and social systems usually develop a structure which does not necessarily follow the pre-arranged pattern set forth in the organizational chart. Indeed, the formal hierarchical system may not facilitate the "being together" of people who should be together; thus it may actually block communication.

Other "communication blocks" may result from the physical locations of particular people; from a poorly planned formal structure; from unrecognized informal

structures which provide channels for the communication of information and feelings in conflict to those expressed by the administration of the hospital. Blocks occur between individuals because of "role expectancies" (the senior consultant is always expected to say more about the patient than the nursing assistant, although he may actually know less because of his limited contact with the patient); or because of divided or conflicting loyalties between members of different hospital services, which run contrary to their basic loyalty to their hospital.

One of the main purposes of any social structure and especially that of the mental hospital, should be to facilitate both the amount and the significance of communication. This is especially true in the mental hospital, because communication is one of the essential elements in the patients' resocialization.

Meetings, especially of all the members of a treatment team, offer a good opportunity for significant communication, yet most participants admitted that it was difficult to have such meetings without immediate loss of time spent with patients. This loss was more than compensated for, however, by the effectiveness of what was done in the remaining time, and by increased morale because personnel had a real part in decision-making.

People also had more understanding of the reasons for the work they were doing. Meetings where only one member of a group attended and reported information and observations back to the team, were not so successful. Everybody wants to be included where plans are to be made upon which his own actions are to be based.

Two grossly different levels of treatment effort—that of the Admission and Acute Treatment Units and that of the Continued Treatment Services—dramatized the recurring complaint about the establishment of treatment priorities. The participants asked whether a new baseline—a socio-psychological treatment program—might not replace custodial care, as the standard upon which all other treatments and programs are superimposed.

Two advantages are apparent. One is the humanitarian value of substituting an active, ostensibly therapeutic program for a less active and essentially non-therapeutic one. Another would be the increased sensitivity of the ward treatment team. It has been rather a common experience to find that patients in custodial settings have been in process of change for some time without this coming to the attention of a custody-oriented staff. A socio-psychologically treatment-oriented staff, so sensitively attuned to its patients that it could respond to the smallest changes, could provide conditions to facilitate or enhance even minute gestures toward improvement.

Not a Complete Treatment Approach

Some workshop participants wished to emphasize, however, that the "therapeutic community" is incomplete as a treatment method, saying that it provides "only the backdrop upon which other treatment approaches are projected." It was reiterated that a socio-psychological treatment program could not be substituted for psychotherapy, chemotherapy or any other active treatment program which might be prescribed for individuals or groups of patients. The approach does, however, provide a favorable environment in which specific treatments may take place, and by sensitizing staff members, might serve to bring treatment to individual patients at a time when they seem most ready to benefit from it.

THE LAST ROMANTIC

By Dr. Whatsisname

Romanticism is almost dead, but not quite. There is still the psychiatrist. Where orthopedists talk of degrees of disability and urologists of polyps of the bladder, the psychiatrist talks of love relationships. Playwrights see the seamy side of life and write dismal stories about it. Psychiatrists see in man an indestructible nobility. The business man speaks of profit, but the psychiatrist sees man's constant striving towards an ego-ideal. The reformer seems bent on taking the joy out of life, but the psychiatrist's goal is to help the patient achieve happiness. The executive thinks of people as pawns in his game, to be moved at his will. The psychiatrist thinks of each person as uniquely individual. To most of medicine, it is nothing if the patient is seen with his pants down or in awkward and undignified postures, for dignity is not part of scientific medical practice. Alone among medical men, the psychiatrist is ever conscious of human dignity.

So all the other strongholds of romanticism have been toppled. Of all the scientists, perhaps of all the workers in the "behavior disciplines", only the psychiatrist clings to the notion of individual dignity, individual potential, individual love. The clergyman, of course, still retains faith in the individual and concern about each individual soul. But "romanticism" is hardly a word one would apply to the theologian.

No, the psychiatrist and only the psychiatrist remains as the spokesman for the romantic. Let us hope that it will be a long time before he succumbs to group therapy without individual interviews, to mechanical laboratory work-ups, electronically interpreted tests, and general automation. We psychiatrists should be kept alive (if for no other reason) as the last living specimen of the true romantic.

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THE FAMILY PHYSICIAN IN FOLLOW-UP PROGRAMS

By CHARLES E. GOSHEN, M.D., Project Director,
A.P.A. General Practitioner Education Project

ONE OF THE MAJOR FACTORS which delays the discharge of many patients or causes their readmission is the inadequacy of follow-up care. Even in those states which have after-care clinics, many discharged patients are "lost" and thus become likely candidates for readmission. In other states, the chances of instituting any formal type of after-care are impossibly remote because of shortages of funds and trained personnel.

It is not unreasonable to conjecture that a third of all first admissions to mental hospitals could be avoided by adequate psychiatric care on the outside; another third of the present hospital population could be discharged if adequate follow-up care were made available.

The obstacles to setting up such a program are, of course, shortages of funds and personnel. We could readily show that the allocation of funds for pre- and post-hospital care would greatly reduce the cost of operating the hospitals. We would still be faced, however, with the personnel shortage.

The General Practitioner Education Project of the A.P.A. believes that there exists a large, untapped personnel resource in the community—the family physicians. If these physicians had some orientation in psychiatric principles, and a close collaboration could be developed between them and the mental hospitals, a sizable follow-up program could be developed.

The family physician possesses an unusual asset which the psychiatrist or the mental health clinic is denied. Whereas the potential psychiatric patient or the ex-patient will often avoid contact with psychiatrists or psychiatric clinics because of fear, bitterness or pride, he will rarely avoid contact with his family physician. Nearly everybody is likely to have this one contact with the medical profession.

Heretofore the family physician has been largely left out of our follow-up care programs, partly because of his lack of confidence or skill in handling psychiatric problems, and partly because he has been ignored by the mental hospitals and the psychiatrists. But the advent of the so-called tranquilizing drugs has placed in his hands something which gives him confidence to tackle some of the problems which he has hitherto avoided. His experience with this handy new procedure will probably convince him that drugs are not really the answer to psychiatric problems, but in the process he is also likely to learn enough about such problems to make him more skillful in handling them and more willing to do so.

There are already preliminary reports that the mental hospital admission rates are dropping. This is undoubtedly due in part to the efforts of the general practitioner. If we collaborate with him closely and keep him informed of the latest trends in psychiatry, we can help him to become the major mental health resource in our country.

Current Practices Surveyed

The General Practitioner Project has made a survey of current practices and attitudes in different parts of the U.S. and Canada about the use of general practitioners in the follow-up care of discharged mental patients. In Massachusetts, the policy is for the hospital psychiatrists to make direct contact with the patient's family physician to help plan an after-care program. The Commissioner believes that a doctor-to-doctor relationship is more likely to be productive and harmonious than a hospital-social worker contact. Continuing programs of this kind could be worked out with the mental health committees of the local medical societies.

In Kentucky, it was said, many indigent patients have no family physician to turn to, and indeed, this is frequently the principal reason for hospitalization in the first place. There have been some attempts, however, to send admission summaries, progress notes and a comprehensive discharge summary to the family physician where one is available. In Florida, a carefully worked-out plan between the hospital and the county departments of health has proved successful; the local department of health follows the case with the family physician, or independently, if there is no family physician. The health department personnel attended a series of orientation courses at the state hospital to prepare them for this role, and plans are being made to offer local physicians similar courses.

In Ontario, Canada, the Inspector of Hospitals for the Provincial Department of Health says that he is becoming increasingly impressed with the need for using the general practitioner for follow-up care. The large areas covered by the Canadian hospitals make it difficult to maintain direct contact between the patient's home and the hospital staff, in spite of the use of traveling clinics. The Department is encouraging the wider cooperation of medical societies and hospital staff.

In Nova Scotia, a psychiatric clinic has been set up in a major population center 60 miles from the hospital. The social worker from the clinic visits the hospital once a month to help patients get ready for discharge. She then contacts the family and has a summary of the case sent to the family physician. She later visits the patient, and discusses the case with the family physician; thereafter, the family physician or the mental health clinic continues the follow-up program. The system was worked out in collaboration with the mental health

committee of the local medical society. (Without such joint policy-making, no such program is likely to get cooperation from the physicians.)

In Georgia, there is a well-planned program through the Department of Health, but little emphasis is placed on referrals to family physicians. Kansas approves of the idea of using the family physician, and suggests that the feed-back of information could go two ways—from the physician to the hospital, as well as from the hospital to the physician. In the Virgin Islands, the objection is again raised that very few patients have a family physician, and in West Virginia, the acting director of the Department of Mental Health feels that working with medical societies poses a problem, partly because many of his hospital physicians are not members of county societies and partly because many are foreign, with a poor command of English. He would be interested in hearing how other people have worked out these problems.

In New York state, after-care is set up through an extensive and elaborate social service and outpatient clinic arrangement. Until recently the family physician was not specifically included, but now the restrictions on releasing information to him have been relaxed, closer relationships will be developed between hospital and family physician.

A number of other states replied. There seems to be general agreement that despite certain difficulties in setting up such a program, the family physician can be an important asset to after-care programs. In the areas where a concentrated effort has been made to enlist his help, the result has been quite satisfactory.

Where psychiatric personnel shortages are most acute, the family physician is often the only resource available. His help can sometimes be supplemented by local public health authorities. Whereas the ideal working relationship seems to be direct liaison between hospital and community physicians, the social service department, welfare department workers or public health nurses can sometimes mediate successfully.

Local medical societies should be invited to participate in the planning and policy-making. Local chapters of the American Academy of General Practice can be counted on to offer assistance.

The general physician himself will gain valuable psychiatric experience by sharing in the follow-up of former mental hospital patients. Indeed the success of such a program can only be assured if the general physician is offered an opportunity to increase his professional knowledge by taking part in well-organized training and orientation programs. Continuing close liaison between the general practitioner and the hospital is important.

Newsletter for Relatives Evokes Family Interest

By AARON S. MASON, M.D., Director of Professional Services
JOSEPH M. SACKS, Ph.D., Chief of Clinical Psychology
and PETER A. PEFFER, M.D., Manager, Veterans Administration Hospital, Brockton, Massachusetts

THE RELATIVES of mental hospital patients can play an important part in achieving the major goal of the hospital—the return of the patient to his home. Yet comparatively little has been done to include relatives in the hospital team or to develop a medium of communication between them and the hospital. We have attempted to remedy this situation at our hospital through a "Newsletter for Relatives," a bi-monthly publication which imparts information not only about the hospital's programs and policies but also about mental illness in general.

The avowed purpose of the "Newsletter" is, of course, to stimulate the relatives' interest in and support of their patients. That it has succeeded in doing so has been demonstrated by the many letters the hospital received after the first issues were mailed, expressing appreciation of the information included, and asking questions about patients or treatment methods. In a few instances, the Newsletter has prompted inquiries from relatives who had shown no interest in their patient for some years.

The Newsletter is intended to provide two-way communication. The readers are invited to submit comments, inquiries and suggestions. When, for instance, one reader asked about mental health literature, the hospital's medical librarian responded in a column giving reading suggestions. A regular feature, "The Question Box", answers inquiries which are felt to be of general interest.

Through the Newsletter, relatives learn about the activities of the various units of the hospital, such as Special Services with its recreation, library and volunteer programs. They are told the best procedure for sending clothing, money or other gifts to their patient. Holiday issues carry lists of gift suggestions and advice about visiting. Of a more general nature are articles on the art of making a successful hospital visit if the patient is withdrawn, deluded or hostile; the meaning of trial visit and other types of conditional discharge; on drug therapy, psychotherapy and other treatment modalities; and on special rehabilitation programs.

The Editorial Board feels that the possibilities of obtaining appropriate material to publish are almost limitless.

Note: A sample copy of the "Newsletter for Relatives" is available on request from Mental Hospital Service. Please enclose a self-addressed envelope with your request.

Special Unit for Electric Convulsive Treatment

By LILLIAN P. FURTADO, R.N., Head Nurse
and LESTON L. HAVENS, M.D., Assistant Physician

Massachusetts Mental Health Center, Boston

OVER the last ten years there have been many changes in the way we give electric shock treatment at our hospital. These changes have made shock treatment a safer and less anxious ordeal and make available to patients receiving the treatment the opportunity to form new relationships and to learn new ways to master anxiety.

An electric shock treatment unit, with its own personnel, quarters and with special services such as group psychotherapy, has replaced the earlier method of treating patients on the wards. At first the treatment team moved from ward to ward and took over space used at other times for general ward activities. Later, all patients receiving electric convulsive treatment were brought to one ward. Neither method was entirely satisfactory, but out of this experience techniques were developed which have proved useful in the present arrangements.

Having a separate unit with its own facilities and personnel reduces the disturbance and anxiety of ward staff and of patients not receiving treatment. The treated patients benefit from its more hospitable atmosphere as well as from continuous medical attention of personnel experienced in the problems shock treatment presents. The unit consists of a suite of rooms formerly used as a ten-bed ward which was converted into waiting, treatment, recovery and breakfast rooms. Personnel are largely drawn from the general wards, to which they return after treatments are completed.

Very early it became apparent that if patients remained in the waiting room by themselves or with an attendant whose only function was supervision, there were many signs of tension: some paced the floor, others sat anxiously biting their nails, and many asked to see their doctors. In this situation the chief nurse became especially useful. She would often discuss with patients their fear of treatment and was able to convey her understanding of this fear and its acceptability. She was also able to assure them that the treatments often helped. This was time-consuming, but it was soon found that extra time spent in this way at the start of a course of treatments reduced the time needed later to bring patients into the treatment room. The chief nurse gradually turned over her waiting room responsibilities to a student nurse, for whom this duty is useful training in helping patients handle anxiety.

Simpler Diversions Found Best

The waiting room is equipped with reading matter and a phonograph to entertain and distract anxious patients, and simple tasks—knitting, making potholders and rolling gauze—have been introduced. Patients' concentration was found insufficient for more demanding activities. A brief experience with television ended when it was found that each electric shock treatment was dramatically reported by an interruption of reception!

Permanent personnel were also introduced into the recovery and breakfast rooms and, as a result, patients have the reassurance of awakening to familiar faces and being assisted in their reorientation by people they know. Reorientation after treatment is often accompanied by great fear and in our experience this fear is best combatted by the presence of familiar and interested personnel. It affords a great opportunity to establish and further relationships. As orientation returns and anxiety subsides, patients often are remarkably free of symptoms, even though they may relapse in a few hours. In this symptom-free period patients may form the first comfortable and trusting relationships they find in the hospital.

Although fear of treatment lessened, as demonstrated by the decreasing need for coercion to bring patients to treatment, there still remained much anxiety and many expressed fears. Group psychotherapy seemed an ideal tool for reaching and exploring these fears. With a resident doctor and the chief nurse as leaders, group sessions were begun, twice a week, first in a room on one of the wards and later in the unit waiting room. We had feared that the frequent changes in the group's composition, because of patients' going off treatment and leaving the hospital, might significantly reduce the group's value. We now doubt that this has been the case. Indeed, the frequent departure of group personnel provides a ready subject of group expression, of particular significance for the depressed patients, so many of whom had suffered the recent loss of important people in their lives. The group meetings are an important step in providing the kind of support patients need to take shock treatment, and to be willing to return if further treatments are indicated.

The unit is more than just a place where shock treatments are given. The patients find that the staff understands their fears about the treatment procedure and they are helped to handle these fears. Thus the treatment experience provides an opportunity to increase the patients' trust of others. By undertaking simple tasks in the waiting period, by sharing feelings of distress with members of the staff and by coming to understand their own and others' reactions to treatment through group psychotherapy, patients have an opportunity to learn new and more mature ways to handle anxiety.

The present organization of the unit entails the use of a student nurse in the waiting room, the chief nurse to supervise activities and prepare medications, a resident doctor and attendant to give treatment, one attendant in the recovery room and another in the breakfast room. (The breakfast room and recovery room attendants are

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Salt Lake City, Utah	*Surgical Supply Center*
Richmond, Va.	*Southern Medical Supply Co.*
Seattle, Wash.	*Aloe Scientific*
Seattle, Wash.	*Scientific Supplies Co.*
Spokane, Wash.	*Physicians & Surgeons Supply Co.*
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also available to insulin shock patients, who usually are ready to eat by the time the electric shock patients have finished.) The total number of personnel is one attendant less than was necessary when treatment was given on the wards. Patients, from each of the wards in turn, come down to the waiting room fifteen to thirty minutes before treatment. The resident doctors give any modifying drugs, pentothal sodium and/or succinylcholine chloride, when indicated, and administer the shock treatments. An attendant, who is regularly present, gives oxygen to patients receiving the modified treatments and helps wheel patients on the treatment stretcher into the recovery room. Use of the Reiter Electrostimulator requires no personnel besides the resident doctor and attendant in the treatment room because, whether with the modified or unmodified procedure, patients do not need to be held before or during the seizure.

After treatment the recovery room attendant and treatment room attendant move the patient from stretcher to recovery room bed. During recovery time, usually fifteen to twenty minutes, the attendant makes observations on pulse and respiration and watches for any signs of distress. When patients have recovered sufficiently to take breakfast, they are helped to the breakfast room. Up to twenty inpatients and twelve outpatients can be treated in a two-hour period.

It is impossible to estimate how large a part the modification of electrical seizures by pentothal and succinylcholine has played in the change we have observed in patients' attitudes toward shock treatment. In the group psychotherapy sessions patients generally express a preference for the modified as opposed to the unmodified treatment. In a separate study, however, we found that there were few differences in patients' attitudes toward the two types of treatment, as measured by the number of patients tense or resistive before treatment and the numbers expressing fear of the procedure before and after treatment. Our impression is that resistance to taking shock treatment decreased before the increasing use of the modified technique and the change correlates best with the changes in the unit arrangements.

The availability of special equipment and experienced personnel in the unit is of special importance when the modified technique of shock treatment is used, because of the potential anesthetic hazards. Patients are rendered unconscious and apneic in the course of this procedure and it is advantageous to have oxygenating and suction equipment readily available.

The unit also gives electric shock treatment on an outpatient basis. Three days a week patients are referred after evaluation from the hospital's outpatient clinic, and treated after the last inpatients. The recovery room has enough beds so that a considerable period of rest can be provided after treatment; as a result, when the patients are returned to relatives in the clinic waiting room, they are clear-headed and steady enough to be taken home. In this way, without any duplication of personnel or equipment, both in- and out-patients can be treated in the same unit.

Evening Treatment Schedule Considered

The original goal of the unit was to make electric shock treatment acceptable to patients. Today there are additional goals and different problems. One problem is the damaging effect electric shock treatment has on the rest of the patient's day. We have considered but have not yet attempted moving the treatment time from the morning to an evening hour. By this means patients might be better able to sleep off the period of confusion that follows treatment and be fresher and clearer than they are now for the day's hospital activities. There might be similar benefits for outpatients, and the added convenience for relatives of being freer after working hours to bring the patients to and from the outpatient clinic.

A continuing problem is to keep patients' emotional needs constantly in focus, for, as is well known, research and the training of staff may distract from patient care; so does concern with the medical niceties involved in giving the modified treatments which demand the preparation of injections and use of oxygenating equipment. In maintaining a sensible balance of the staff's interests between training research and patient care, the chief nurse especially carries the role of guardian of the patients' interests, in order that the attention of the unit does not center on equipment or research.

The isolation of the unit from the rest of the hospital is also a threat to the best care of patients, through discontinuity of care and lack of communication with those responsible for other therapies. This isolation is minimized in our situation by the fact that the staff, after treatments are completed, is assigned back to general ward responsibilities; this makes possible a continuing contact with shock-treated and other patients and the utilization of what has been learned of the patients in the shock treatment setting. The chief nurse further integrates the unit into the hospital by frequent visits with patients on their wards before and after treatment.

Award Given Daily for Cleanest Room

An attendant at Patton State Hospital, California, is shown pinning the prize badge on the door of the room which won the daily competition for being the neatest. This contest, which is conducted on the wards of the Receiving and Treatment Building, has stimulated the patients to take a real interest in their surroundings. Nursing Service employees donate small treats, such as cigarettes or cookies, to the patients in the winning room.

An Employee Orientation Program

By WESTON D. BERGMAN, JR., Personnel Officer
Eastern State Hospital, Lexington, Kentucky

The personnel section is a comparatively new addition to the organization of many mental hospitals. Like most newcomers, it is confronted with several problems. These relate primarily to the establishing of this new section within the organization so that it may assume a vital role in meeting the personnel needs of the hospital.

The new personnel section has initially, therefore, a two-fold purpose: the integration and clarification of its own relative position in the organization, and the establishment of an effective and workable program for hospital employees. One of its first concerns is to initiate an activity which meets existing needs and can also provide a basis for future expansion.

When our personnel section was formed in January 1956, it was necessary for us to investigate those needs which had to be met at once. Some of the most obvious were: the need to introduce new employees to the operation of the entire hospital; the need for older employees to know about the operation of sections other than their own; the need to discuss with employees the use of and reasons for various hospital policies and procedures; the need for employees to understand hospital organization; and finally, the need for employees on all levels to identify themselves with the central purpose of the hospital, namely, to give the best possible care and treatment to the mentally ill.

It was felt that these needs could best be met by an activity designed to present the functions and purposes of each section as well as of the hospital as a whole; to show how the hospital was organized to perform these functions; and to explain the reasons for various policies and procedures and how they contribute to the operation of the hospital.

We therefore established a hospital-wide orientation program which provided a simple yet effective basis on which to establish a more elaborate future program.

We felt that the best method of introducing an untried program was by making a simple beginning, using what resources were available at the time, and gradually enlarging the program as it became firmly established.

Because of the organization of our hospital it seemed logical for us to initiate this orientation program in the Business Section. Experimental sessions could be started in this section which would help us in evaluating the program before attempting any expansion.

Consultation resulted in a series of meetings which were attended by selected employees and section heads from the business section. These meetings consisted of talks by the hospital staff, visits to various departments and discussions of hospital organization.

Employees Help in Designing the Program

The first sessions resulted in favorable reactions from both section heads and employees, and provided us with more information about how the program should be designed. It was our intention to include eventually all sections of the hospital. Using information obtained in these first meetings, we continued this program and started to expand it.

Other section heads were constantly informed of our progress, but no section head was asked to take part or to send participants until it was felt that the program had developed enough for inclusion of that section, and until interest had been expressed by the section head.

The Superintendent, Business Administrator and Clinical Director were asked to give talks presenting the operation of the hospital as a whole. Section heads and other employees were asked to take part, presenting subjects which we felt pertinent to our effort. Each subject was presented clearly and concisely with an attempt to keep the presentation on the level of employee understanding.

Any subject which contributed to the information needed was incorporated in the program. These subjects ranged from the function and operation of departments to such topics as, "Working with Mental Patients", "Fire Rules and Regulations", "The History of the Hospital" and "Work Orders and Requisitions."

As each additional section was included, new problems became apparent and new subjects were introduced. We found that having one or two sessions per week for a cycle of six weeks was most effective. The actual meeting time was kept flexible, although we normally met from 1:30 P.M. to 3:00 P.M.

Since our program ran in cycles, it was desirable to have the content of each session systematized, even though we continually added topics. This allowed those absent at a particular session to make up this session in the following cycle. It also allowed us to keep accurate records of individuals completing the program.

The number of participants did not exceed the number which could efficiently make visits to all sections. We found that it was inconvenient to include over twenty-five employees. Before we included employees from a particular section, the section head was asked to take part on the program. This served to familiarize him with our efforts as well as to pave the way for the attendance of his employees.

Later a quota was fixed for each section to send. This quota included both new and old employees and was flexible enough to allow for the particular needs of the section. Section heads were encouraged to sit in on these meetings as well as to take part in presenting certain topics. Once an employee was assigned, attendance was made compulsory and excuses were granted according to existing hospital policy on absences.

When the program was first initiated, it was felt that some method for evaluating results would be needed. We designed the first cycle and have continued in the following cycles to devote the last session to summarizing the entire program and discussing the effectiveness of the meetings. We devised a questionnaire to be given to employees at this last session which gave them an opportunity to present their comments and criticisms. This questionnaire is still in use and employees have continued to assist us in re-evaluating the program. This keeps us constantly aware of unmet needs. The results of these questionnaires, distributed throughout the hospital, also provide good advertising for the program.

A typical program now offered to our employees is as follows: *1st Meeting:* Period of getting acquainted; introduction — history of hospital; function of clinical section; function of service section. *2nd Meeting:* Descriptive color slides of hospital; talk on working with mental patients; presentation on recreation department; visit to dietary section. *3rd Meeting:* Talk on care of equipment and function of canteen; presentation of the supply section; discussion of work orders and requisitions; visit to the supply section; visit to cold storage area; visit to maintenance department. *4th Meeting:* Personnel information; presentation on occupational therapy department; visit to occupational therapy. *5th Meeting:* Talk on functions of volunteer co-ordinator; presentation of laundry; visit to laundry. *6th Meeting:* Presentation of social service; presentation of nursing service—nursing care, nursing education; adjunctive service; visit to nursing section. *7th Meeting:* Discussion of fire rules; fire demonstration, Lexington Fire Department. *8th Meeting:* Summary; questionnaire presented and entire program discussed; refreshments.

It is now over a year since the first orientation program was presented and we have experienced remarkable growth. This program now includes all sections of the hospital and offers new and old employees alike the advantage of a comprehensive glance at the operation of the hospital. It has served to systematize the orientation of new employees, for each section conducts an informal orientation of its own work and sends us the new employee for hospital-wide orientation. We believe that it has been a contributing factor in reducing our labor turnover, that our morale has been improved and that employees of all levels have a better conception of the factors involved in cooperating with each other.

Although we realize that orientation is not an end in itself, we think this program provides a needed service for our organization. The program can form the basis for the development of supervisory training, in-service training and other activities of an expanding personnel program.

FACING LINEN LOSSES REALISTICALLY

By HELEN M. EDGAR, Director of Nursing
Philadelphia State Hospital, Pa.

HOW MANY PSYCHIATRIC HOSPITALS can say that they do not have unexplainable linen losses from time to time? Much loss is sustained because some patients are destructive, and will tear a dress or shirt into ribbons. Others will leave the ward on a work detail, and return minus socks, coat, galoshes, raincoat, etc. Some try to hoard inventory items. Others will block drains with items of clothing. All these factors tend to create our "unknown loss" which can only be replaced by withdrawals from the warehouse.

While a linen control system must be administered scrupulously to avoid unnecessary losses, too rigid rules can produce undesirable effects. If the ward personnel are held accountable for each and every item of lost linen or clothing, and unexplainable losses are regarded skeptically or reproachfully, the personnel themselves will attempt to accumulate an extra supply in the linen room to replace lost articles. Thus while the ward manages to keep an apparently clean record on losses, the hospital linen stores have inexplicably dwindled. This creates a situation difficult to explain from a budgetary standpoint.

In our hospital, we prefer to replace genuine losses as they occur, instead of waiting until they show up as great losses and have to be replaced in quantity. We have accordingly set up a linen control system that allows prompt replacement of lost items.

First we established a basic quota of linen needs for each ward. This was done through the Nursing Service, since these people best know the patients' needs. It can be established either on a ward or building basis, taking into consideration the standard desired; the existing inventory; the average needs per patient, and the type of patient involved.

Once the basic quota has been established and the linens supplied, a careful physical inventory is taken each month, and a final monthly inventory sheet is prepared by the Ward Clerk; a copy is kept in the ward files and in the main nursing office. The inventory must show clothing actually in use by patients and the location of all the items on the inventory. The final count is submited to the head nurse for her approval and this inventory becomes the basis for control and replacements.

Incoming and outgoing shipments of laundry are carefully checked and receipted both by the building and the laundry. If one finds a discrepancy in the other's count, a phone call is made immediately to get it straightened out.

Destruction exchange then becomes the responsibility of each individual building. All damaged items must be sorted and sent to the warehouse, accompanied by a list of what, in the opinion of building employees, the pieces represent. If the warehouse employees are in agreement with the building count, they will submit figures to the business administration office, who will authorize replacements and record them on IBM cards. If, on the other hand, the warehouse people do not agree with the building employees as to the replacements needed, then representatives from the departments concerned or the Laundry Committee* will endeavor to reach a meeting of minds.

Worn-out bedding and household linen supplies can be taken out by the laundry and replaced directly from their own stock. The laundry then requisitions replacements from the warehouse on an exchange basis. But items of clothing are to be exchanged directly between warehouse and building or ward.

All clothing, except hosiery, should be marked in the warehouse, and the building number indicated. Bedding and towels are marked with the name of the hospital. Certain items which already have the name of the state or "Hospital Property" woven in need no other markings.

Each week, from the IBM cards, the business office makes a summary available to all supervisors responsible for requisitioning supplies. This summary, checked against the basic inventory, enables them to check readily whether the inventory has been filled and to requisition items which are short. At the end of each month, a total summary is made available, and department heads can readily pick up any unit which shows unusual losses. This system also serves to challenge unit supervisors to keep their losses low.

* *When occasion arises, the Laundry Committee meets; it consists of the business manager, laundry manager, accountant and director of nursing.*

Salvaged Linen Used To Make New Items

The linen control system at Richmond State Hospital, Indiana, includes a textile salvage operation which has produced very economical results.

The salvage operation begins with the store clerks' turning all torn items, which the wards have exchanged for new ones, over to the sewing room each day. The sewing room workers sort these items carefully. All items that are completely destroyed or worn too thin for salvage are returned to the warehouse where they are issued as cleaning rags. All items that need only be mended are very neatly mended and returned to the warehouse as stock to be issued. All large pieces of good cloth are kept in the sewing room and used as material from which new items are produced. Large pieces of sheets are made into pillow cases. Pieces of bath towels are made into new wash cloths. Old torn bed spreads are made into bath mats. Small scraps of good cloth are made into pot holders, hot pads, bed slippers, etc.

This salvage operation has reduced our need for purchasing pillow cases, washcloths, etc. Having a rag supply in the warehouse, free for the asking, has discouraged employees from using their torn and worn out linen supplies for cleaning rags.

EVELYN AMMON, Inventory Clerk

Purchasing Procedures in Furnishing a New Psychiatric Institute

By DELBERT C. MESNER, Business Manager, Nebraska Psychiatric Institute, Omaha

PLANNING the equipment and furniture was considered of major importance in establishing the new Nebraska Psychiatric Institute building. (See MENTAL HOSPITALS, September 1955.) The Director of the Institute wished the building, its furniture and equipment to provide a pleasant setting for a modern therapeutic psychiatric program. Moreover the Institute was to contribute to increased public acceptance of psychiatry, and the appearance of the building and its furnishings were important.

Still another furnishing problem was presented by the multiple functions of the building. The 96 beds are divided into nine wards for different types and sexes of adult patients, for children and for research subjects. Two separate outpatient divisions, one for children and one for adults, are included in the building. These required different planning and furnishings.

One of the principal purposes of the Institute is the education and training of varied groups of psychiatric and ancillary personnel. Space and furnishings for a lecture hall, class rooms, conference rooms, trainee offices, and auxiliary educational needs, such as audio-visual aids, are included. The Research Department has additional space and equipment.

The Nebraska Psychiatric Institute is a joint project of the University of Nebraska and the Board of Control of Nebraska. Financing of the new building was shared by these organizations, plus participation by the Hospital Advisory Council. Early in planning for the building, a joint committee on equipment and furniture was appointed.

Furniture Budget Established

The committee's first task was to furnish estimates of furniture requirements. As soon as preliminary building plans had been agreed upon, a proposed furniture list was prepared for each room of the building. Estimated prices were assigned and totals arrived at for each room and for each area of the Institute. The total amount was established as the budget for equipping and furnishing the building and funds were encumbered, about three years before occupancy.

The room by room lists were used many times during further planning of the building. The architect found many uses for them; for example, the central business office equipment list indicated that the electrical outlets planned were insufficient. Additional outlets were accordingly provided in the final plans.

The initial room by room furniture lists were modified from time to time as plans progressed on building and as operating procedures for the new building were established.

A search was begun for the items required; it involved most of the professional staff of the Institute. Purchasing personnel were very actively involved. Trips were made to furniture and equipment showings and to conventions with displays. Advertisements in periodicals were watched for items in which we would be interested. The problem was discussed with furniture and equipment sales representatives and their suggestions solicited. Rather than accepting whatever was offered, we searched continuously for items best suited to our needs.

Early in equipment planning, the Director of Purchases of the University of Nebraska agreed to supervise the writing of specifications and other phases of purchasing work. He assigned one of his staff to work with our group and develop specifications.

Each room of the building was sketched on graph paper to scale. Copies of the room sketches were made available to Institute personnel for use in planning the amount and size of furniture, then furniture to scale was drawn in room layouts. This planning was to be particularly useful when the furniture arrived; it aided the storekeeper in placement within the rooms.

About a year before occupancy, intensive work was started on furniture specifications. This problem was of paramount importance. The Institute was different from buildings previously equipped either by the University of Nebraska or the Board of Control, and there was no precedent to follow. Our mistakes would be our own.

The specifications had to serve several purposes. They were to be a means of communicating the wishes and needs of the Director and his staff to the other state groups which would approve the purposes. Competition was to be encouraged in order to secure the items at a moderate cost, within the budgeted amount. The state law demanded open bids and finally, quality furniture had to be secured and cheap imitations avoided.

Forms were prepared to use in drafting specifications, a sheet for each item. The back of the sheet indicated the room or place where the item would be located. The original room by room furniture lists were used to build the list of separate furniture and equipment items, and the number of each to be purchased. This list, showing where each item was to be placed, proved invaluable at the time of delivery. The storekeeper knew where each piece of furniture and equipment belonged.

Use of Pictures Helpful

The prepared form called for many details common to all furniture but every item presented its special problems. Where possible, pictures of the item specified were cut out and pasted on the specification sheet. (Pictures came largely from supplier catalogs.) The use of pictures was found valuable to all who referred to the sheets.

Using this system, the Director and his staff always knew what the purchasing department was requesting. State officials reviewing specifications were able to understand the item immediately. Suppliers were complimentary, as their task was simplified

and fewer questions raised. Upon delivery, identification and checking of specifications were expedited. Since purchasing was completed, we have referred to the specifications innumerable times to secure model numbers for repairs, to check special features of equipment, or to requisition additional items.

The furniture and equipment specification sheets were classified into nine categories applicable to groups of suppliers, to facilitate receiving bids. A group number was assigned each category and individual numbers were assigned to each item within the categories. The larger categories were furniture, kitchen equipment, medical equipment, housekeeping equipment, office furnishings, and occupational and recreational equipment. In spite of some overlapping the division proved useful; for example, bids for furniture for patient rooms and lounges were solicited, not only from hospital supply houses, but also from contract departments of local stores and from suppliers for hotels, colleges and universities.

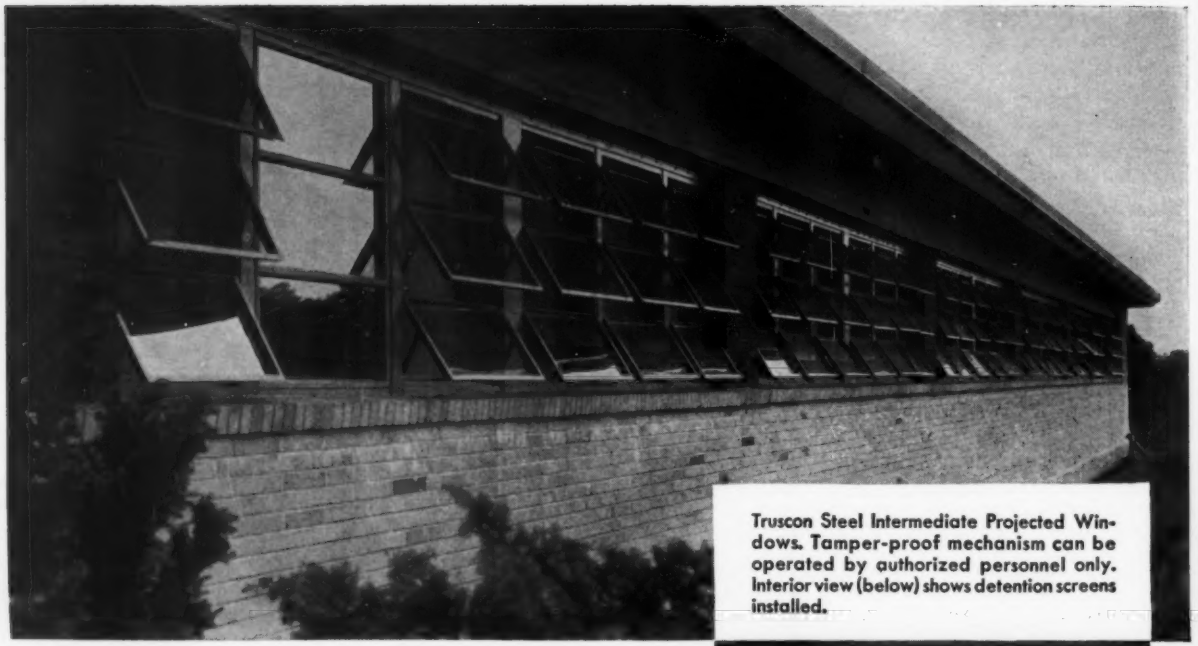
The specification sheets were duplicated, using two colors of paper. Two copies, one of each color, were sent to suppliers, one for their records and one to be returned with bid prices. In most cases, the bids were on the basis of specifications, with no modifications or changes. Consideration of bids, in most instances, was simply on a price basis. In practice we found that, with the proper completion of the specification sheet, the procedures that followed became automatic and routine. Communication between purchasing personnel and the Institute staff was simplified.

Placement Handled Efficiently

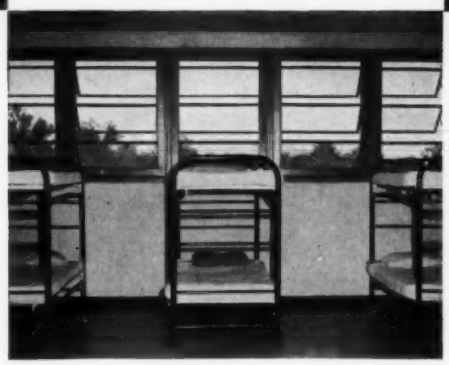
With the pictures and detail in specifications and with room numbers where material was to be placed, the small receiving crew was able to operate efficiently; they received, assembled, marked and placed thousands of items in the few weeks before opening. For the most part, furniture and equipment were shipped directly from the factory. While extra labor was required in assembling, savings in bid prices more than offset this.

Handling of shades, drapes and other window equipment called for a different procedure. A number of firms were invited to send representatives to tour the building and discuss with personnel the uses of various areas and appropriate window treatment. The representatives were then asked to present a complete plan of window treatment and price. A number of excellent plans were presented, worked out by experienced interior decorators. The variety of uses of the building and our desire to stay away from a repetitive institutional atmosphere permitted a large firm to utilize quality remnants and quote a very favorable price, comfortably within the budget allowance.

The Institute was furnished on a minimum budget. Good planning and proper furniture and equipment have made it efficient and well adapted to our purposes. Attention to interior decorating and purchasing of attractive and varied furniture have made the building pleasant and, in some areas, a showplace. The furniture is of good quality and will serve its purpose for years.



Truscon Steel Intermediate Projected Windows. Tamper-proof mechanism can be operated by authorized personnel only. Interior view (below) shows detention screens installed.



Fresh air and sunlight...

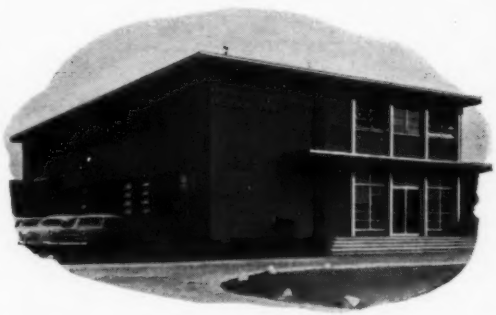
PLUS RESTRAINT

Look at that sweep of fresh air and sunlight designed into the new Kentucky Children's Bureau. Certainly no appearance of restraint. But, it's there!

The windows are Truscon Steel Intermediate Louver, fitted with detention screens. Easy-acting tilt-out ventilators operate simultaneously to provide precisely controlled ventilation and to close tightly to provide positive weather protection. The important point is that the degree of vent opening is controlled by an *authorized attendant only.* The arrangement is tamper-proof. Principal restraint is provided by the detention screens.

The Intermediate Louver is just one of many types of Truscon Steel Psychiatric and Detention Windows designed to conceal or minimize all indications of enforced restraint. They are carefully engineered to protect patients against self-injury and to prevent escape.

Your nearest Truscon representative will be happy to work with you and your architect in the selection and application of the proper psychiatric or detention window for your needs. Write Truscon for latest steel window catalog.



Kentucky Children's Bureau Reception Center, Lyndon, Ky. Arrasmith and Tyler, architects; Rostetter Construction Co., contractor.

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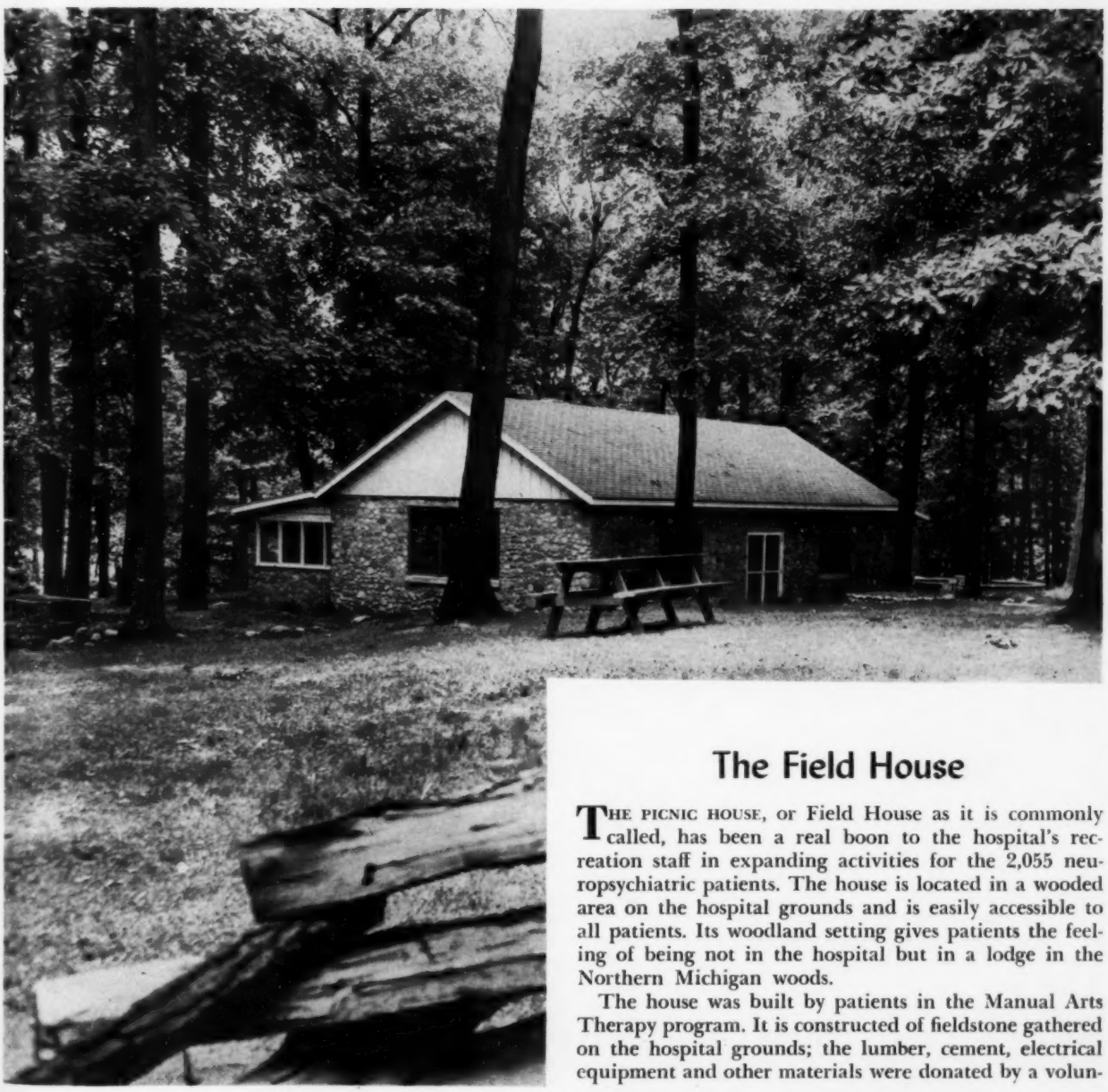


The Field House

THE PICNIC HOUSE, or Field House as it is commonly called, has been a real boon to the hospital's recreation staff in expanding activities for the 2,055 neuropsychiatric patients. The house is located in a wooded area on the hospital grounds and is easily accessible to all patients. Its woodland setting gives patients the feeling of being not in the hospital but in a lodge in the Northern Michigan woods.

The house was built by patients in the Manual Arts Therapy program. It is constructed of fieldstone gathered on the hospital grounds; the lumber, cement, electrical equipment and other materials were donated by a volun-

The Field House (continued)

teer organization. It consists of one large room, a screened porch running the full length of the building, and toilet facilities for men and women. A portable gas generator provides electricity.

The interior has a large fieldstone fireplace, rustic beam rafters and wagon wheel chandeliers with brass lantern-type fixtures. Animal trophies adorn the fieldstone walls. The house is furnished with attractive aluminum lawn furniture with spun plastic coverings.

Outside there are two fireplace grills, located at either end of the building, and picnic tables. A split-rail fence around the yard adds a rustic touch.

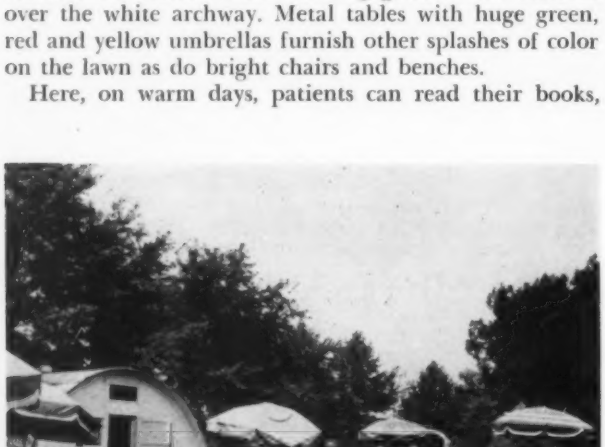
This facility lends itself to a variety of uses, both indoor and outdoor: picnics, dances, games, parties, club meetings, entertaining visitors, and the like.

The Library Patio

WHITE PICKET FENCING, colorful lawn furniture and flower borders were used to create an extremely pleasant and useful area for outdoor library activities. This was achieved, through the generosity of a service organization, by fencing in the large lawn at the rear of the hospital's Library Hut.

The lawn is flanked on two sides by a brick corridor, on the third side by the Hut, and on the fourth by a white picket fence with an arched gateway. Shrubs and evergreens line the south corridor while white trellises with climbing roses lean against the east corridor, the Hut wall and the picket fence. In the spring, bright red and yellow tulips brighten the flower borders; pink and red roses gladden the eye during June. Later in the summer, flame and purple petunias add a touch of pleasing color; then horizon blue morning glories next blossom over the white archway. Metal tables with huge green, red and yellow umbrellas furnish other splashes of color on the lawn as do bright chairs and benches.

Here, on warm days, patients can read their books,



magazines or newspapers. When the library is not using the area, recreational activities are often scheduled. Patients often bring their visitors here for a chat in pleasant surroundings. The lawn, however, is particularly enjoyed by two groups of Special Treatment patients who visit the library one afternoon each week. As these thirty men do not have much opportunity of getting out of doors, they appreciate this lawn visit very much.

The latest issues of the library magazines are arranged on a library cart placed in the center of the patio where the patients can make their choice of reading material as they enter the lawn area. They sit in the sun or in the shade as they wish, and exchange their magazines at will. The librarians or volunteers are always on hand to encourage interesting reading.

On especially warm days, cool fruit punch is served to the group before they settle down to read. Every visit ends with a treat of homemade cookies furnished by one of the volunteer groups.

Inspection Policies Changed for Certain Hospitals

After January 1st, 1958, mental hospitals can be inspected either by the Joint Commission on Accreditation of Hospitals, the Central Inspection Board of the American Psychiatric Association or both. This was announced by both organizations on the 15th of July, 1957.

The Joint Commission will survey and approve mental hospitals on the same basis as it surveys and approves other hospitals—i.e. as hospitals, without judging the actual psychiatric treatment program. It will not inspect hospitals and schools for the mentally retarded.

The Central Inspection Board of the A.P.A. will continue, as it has in the past, to inspect and rate all types of mental hospitals on the basis both of their physical and medical facilities and their suitability for the care and treatment of psychiatric patients.

Such inspections will be made only on request and in the order in which the requests come in, and will include both public and private hospitals, as well as hospitals and schools for the mentally retarded. The institution will be approved, conditionally approved or not approved for its specific purpose and the institution will be designated accordingly in the American Hospital Association's Administrative Guide which is issued annually. A sliding scale fee, based on the number of beds, is charged for the inspection to defray the actual cost to the A.P.A.

Present A.P.A. Contracts Not Affected

The Joint Commission will issue its regular certificate to a mental hospital which it accredits fully as a hospital; one-year approvals do not carry a certificate, but the hospital will be reinspected at the end of that time. These inspections are without cost, but the hospital must make formal application to the Joint Commission. It is recommended that all hospitals apply for this service. Some state Blue Cross Plans restrict their benefits to patients in hospitals approved by the Joint Commission.

This change in policy will not apply to mental hospitals which are at present under contract for A.P.A. inspections, nor will it apply to institutions already inspected by the A.P.A., but whose rating has not yet been completed. All mental hospitals already accredited or in process of being accredited by the Joint Commission on the basis of inspections and recommendations already made by the A.P.A. will retain their accreditation until a future survey indicates a change of status.

The Central Inspection Board has completed inspection of state hospitals in 38 states; it is now working in two other states, leaving only Alabama, Colorado, Florida, Minnesota, Montana, South Carolina, Tennessee and Wisconsin to be done. Private mental hospitals and both public and private hospitals and schools for the mentally retarded are also being inspected by the C.I.B., with some 25 already inspected.

A.P.A. Inspections are based on the Standards for Hospitals and Clinics as outlined by the A.P.A. Committee on Standards and Policies of Hospitals and Clinics. These standards are concerned not only with the physical plant, but set up standards for personnel ratios, treatment programs and activity programs which are peculiar to mental hospitals. A.P.A. approval, therefore, signifies that the hospital is a fully accredited institution for the care and treatment of psychiatric patients.

People & Places

PENNSYLVANIA: Dr. Sewall replaced **Dr. Earl P. Brannon** who was appointed manager of the Coatesville VA Hospital, succeeding **Dr. Henry Luidens** who resigned. . . . **Dr. Edward R. Bennett,** formerly director of professional services at the VA Center, Biloxi, Miss., became head of the Pittsburgh VA Hospital. . . . OHIO: The Department of Mental Hygiene and Correction has appointed **Dr. Ralph M. Chambers,** formerly Chief Inspector of the A.P.A. Central Inspection Board, to serve as a consultant on the Department's long-range construction program. . . . **Dr. E. A. Baber,** who before his retirement served 33 years as superintendent of the Longview State Hospital, Cincinnati, died in March. . . . HERE & THERE: The Brockton, Mass., VA Hospital is grand award winner of the 1956 Hospital Safety Contest. . . . **Mr. Clarkson Hill,** business administrator of the Institute of Living, Hartford, Conn., has been elected a director of the National Health Council. He is also a director of the National Association for Mental Health and treasurer of the Connecticut Association for Mental Health. . . . **Dr. Roy Cameron Sloan,** former acting superintendent of the Big Spring, Tex., State Hospital, has been named clinical director of the Logansport, Ind., State Hospital. . . . **Dr. Duane Sommerness** has been appointed to the superintendency of Traverse City, Mich., State Hospital, the post left vacant by the death of **Dr. R. Philip Sheets.** He came from Fergus Falls, Minn., State Hospital where he was clinical director. **Dr. Norton H. Bare** became superintendent of Huntington, W. Va., State Hospital replacing **Dr. Hiram Davis** who was appointed commissioner of the Virginia Department of Mental Hygiene and Hospitals. . . . **Dr. John J. Blasko,** former Commissioner of Mental Health for Connecticut, has been appointed Chief of the Psychiatry Division, N. & P. Services, Veterans Administration Central Office, Washington, D. C. . . . **Dr. George L. Warner,** assistant director of Marcy (N. Y.) State Hospital, is the new director of Craig Colony, Sonyea, N. Y. . . . Several institutions have had their names changed in recent months: Langley Porter Clinic in San Francisco becomes the **Langley Porter Neuropsychiatric Institute.** . . . Parsons, Kansas, State Training School was changed to **Parsons State Hospital and Training Center.** . . . The North Shore Health Resort Company in Winnetka, Ill., is now known as the **North Shore Hospital for Psychiatric Treatment and Research.**

Book Reviews

GUIDE TO MEDICAL WRITING: A Practical Manual for Physicians, Dentists, Nurses, Pharmacists. Henry A. Davidson, M.D. 338 pp., $5.00. New York, Ronald Press, 1957.

Chapters 3, 4, 6, 9, and 10 of this useful and highly readable volume should be read, pondered, and reread by everyone who contributes even occasionally to professional journalism. The remaining chapters should be kept handy for reference whenever you are preparing a professional article or book. For Dr. Davidson has set forth succinctly and often wittily almost everything you need to know about the technique of communicating with your professional colleagues via printed words.

"An apt title," he begins Chapter 3, "is insurance that your article will be read. . . . Measure the title by four standards: (1) indexibility, (2) specificity, (3) clarity, and (4) brevity."

"If you don't want your paper buried in the library," he begins Chapter 4, "you had better hook reader interest in the opening sentence. [Otherwise] most readers who leaf the journal will skip your opus."

And Chapter 6, entitled "Rx for Readability," is equally to the point: "You will not learn how to write gracefully by reading this book. No one can give you that talent. However, the primary requirement in science-writing is to be understood. The goal is clearness, not elegance. Here it *is* possible to give you some tips."

The tips which follow could—if adhered to by scientific writers—revolutionize the process of transmitting ideas from one mind to others. Rewrite any sentence which exceeds 30 words or so the first time round. Don't write "therapeutic armamentarium" when you mean "list of drugs." Ruthlessly blue-pencil such turgidities as "it can readily be seen that," and "on the other hand, it should be noted that surgeons generally recognize that . . ." And always keep firmly in mind what should surely be preserved in scientific nomenclature as "Henry Davidson's axiom":

"Anything that ***can*** be misunderstood ***will*** be misunderstood."

The author, well-known as a psychiatrist and mental hospital administrator, is also editor of the *Journal of the Medical Society of New Jersey;* perhaps for that reason, he has at his fingertips many choice examples of how not to write. His central chapters describe with much helpful detail—as if a surgical operation were being described—the process of converting a confused first draft into a straightforward, logical, readable—and publishable—article or book chapter.

The book has a few flaws. The short sections on scientific method, for example, are hardly adequate to the topic and should have been expanded or deleted. The wealth of detail on such topics as capitalization, punctuation, and spelling will no doubt interest editors more than contributors. Dr. Davidson enjoys his quips so heartily that he uses several of them twice. But none of this detracts from his volume's dual usefulness:

First, by reading it through, you should be able to improve the accuracy and readability of your own style of scientific writing.

Second, by keeping it near your desk, you can turn to it for help during such chores as footnoting an article, casting percentages into a form that is accurate yet easy to grasp, drafting summaries which really summarize and conclusions which aptly conclude, or correcting proofs in such a way that editors and typesetters will understand what you want done.

EDWARD M. BRECHER
West Cornwall, Connecticut

Mr. Brecher is well known as the author, with his wife, Ruth, of numerous articles on mental and general health subjects in popular magazines.

REMOTIVATING THE MENTAL PATIENT by Otto von Mering and Stanley H. King. Russell Sage Foundation, New York, 1957, 207 pages, $3.00.

A social anthropologist and a psychologist joined forces to write this book. From a rather wide range of observations and experiences in mental hospitals, they have drawn generalizations as to the types of care they saw long term mental patients receive. They illustrate vividly notable improvements and demonstrations with actual case histories—using a ward rather than a patient for the history.

Characteristic of the book are the titles (also used as chapter headings) the authors have applied to concepts and patterns of mental hospital care: The Legend of Chronicity; the Museum Ward (the regressed ward); The Moving Ward (total push activities); The Family Ward (social roles and inter-action among patients are family-like); The House of Miracles (lobotomy ward); A Family of Elders (geriatric ward); Cafeteria Training (an extension beyond habit training to improve social skills of patients). The heart of each chapter is a description of a successful demonstration of a social remotivation technique. Social remotivation is the term the authors apply to what they consider is a profitable treatment approach to the long term mental patient.

Much of the material presented is not new. The philosophy of the authors is well accepted and administrators have been seeking for some years to implement these ideas—if under different names. Two good ideas, however, deserve wider use. One is to let patients help other patients; the other is to make one employee primarily responsible for the welfare of a small group. The idea, in both cases, is to promote meaningful interaction.

The book, which is easily read, offers an optimistic philosophy and approach to the treatment of the long term mental hospital patient. It is useful for teaching purposes, particularly for nursing students and aides, for those working in the various rehabilitation fields and for volunteers.

LUCY D. OZARIN, M.D.
Washington, D. C.